SOUTH CAROLINA
Department
OF
Disabilities
AND
Special Needs

UTILIZATION REVIEW MINUTES

Utilization Review Date: _____

SSN : _____ DOB : _____

Medicaid # : _____

Based on the ICF/MR Level of Care criteria, the Utilization Review Committee has determined that:

_____

(Consumer's full name)

☐ Meets ICF/MR Level of Care continued stay criteria.

☐ Does not meet ICF/MR Level of Care continued stay criteria.

Negative findings associated with level of care, quality and/or cost of services:

☐ YES (If yes, explain) ☐ NO

_____

_____

_____

_____

Utilization Review Committee Signatures:

_____ _____

_____ _____

_____ _____

Next Utilization Review Date: _____

DDSN UR (8/03)